

MEDICAL EXPENSES VERIFICATION – PUBLIC HOUSING

TO: _____ Date of 1st Request: _____
Name of Medical Provider Date of 2nd Request: _____

Address City, State Zip Code Telephone Number Fax Number

RE: _____
Applicant/Participant Name SSN

Applicant/Participant Address City, State Zip Code

Dear Sir/Madam;

We are required to verify the incomes, expenses and other information of applicants/participants for eligibility and continued occupancy in the Public Housing Program/Leased Housing Program. We ask your cooperation by supplying the information requested below about the referenced person. We will use any information you provide only to determine the family's eligibility and rent, and pledge to keep the data in strict confidence.

We would greatly appreciate your prompt return of this form. Note that the person referenced has authorized your release of the information. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

CHA Employee Name Telephone Number Fax Number

APPLICANT/PARTICIPANT RELEASE OF INFORMATION

I hereby authorize the above captioned verifier to release the information requested below.

Name: _____ Signature: _____ Date: _____

TO BE COMPLETED BY MEDICAL PROVIDER/PHARMACIST

1. Please indicate the type of service you provide to the applicant/participant:

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician Care | <input type="checkbox"/> Dental Care | <input type="checkbox"/> Hospital/Clinic Care |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Medical Office visits/Co-pays | |
| <input type="checkbox"/> Medical Transportation | <input type="checkbox"/> Over the Counter Prescriptions | <input type="checkbox"/> Other, please specify: _____ |

2. Payments made by the applicant/participant during the previous 12 months: \$ _____

3. Prescription costs **paid for by the applicant/participant** during the previous 12 months:

<u>Cost</u>	<u>Paid by Insurance?</u>	
a. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

* If you need additional space, please use another blank page or attach a patient history print out from your pharmacy.

I certify that the above information is true and correct.

Name of Person Completing Form

Title

Signature

Date

Name of Company

Telephone Number

Address

City, State

Zip Code

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

